Dear Healthcare Provider,

___________________________________, an applicant of the Lone Star College-Montgomery Radiologic Technology Program, has declared that he/she has either been employed or has been a volunteer at your institution. Since we value our prospective students’ medical imaging experiences and their additional insight into the profession, they have the opportunity to receive additional consideration in our program’s admission process.

In order for our program to recognize the applicant’s experience, we require verification of the above referenced individual’s work/volunteer experience while under your supervision. Please provide a response to all information requested on the Healthcare Experience Verification Form. **All information must be submitted no later than October 8, 2012, in order for the applicant’s information to be considered in the selection process.** Following completion of the form, it should be directly mailed to the Radiologic Technology Program at the address listed below. Please place your signature across the seal of the envelope to ensure authenticity if the student intends on hand delivery to the college.

LONE STAR COLLEGE-MONTGOMERY
Division of Natural Sciences & Health Professions
Attn: Radiologic Technology Program
3200 College Park Drive
Building B, Suite 120
Conroe, TX 77384-4077
936.273.7012

Thank you for taking the time to complete this form, and please feel free to contact me if you have further questions regarding this request.

Sincerely,

Dr. Francis C. Ozor, Ed.D., RT(R)
Director, Radiologic Technology Program
Lone Star College-Montgomery
3200 College Park Drive
Conroe, Texas  77384
936.273.7412
fcozor@lonestar.edu
RADIOLOGIC TECHNOLOGY PROGRAM

MEDICAL IMAGING EXPERIENCE VERIFICATION FORM

APPLICANT NAME: __________________________________________ Check One:  Employee_______ Volunteer_______

Actual Dates of Employment/Volunteer:  From ____/____/_____ To ____/____/_____

Hours per week (if employment): ___________ Total Hours (if volunteer experience): ___________

Type of Work/Duties Performed: _____________________________________________________________

Name & Title of Contact Person Completing Form: ____________________________________________

____________________________________________________________________________________

Healthcare Institution: __________________________________________________________________

Address: ___________________________________________________________________________

Phone Number: (____)____________________

Signature of Supervisor/Representative: ____________________________________________________ Date: ______________________

(Contact Person Completing Form)

NOTE FOR SUPERVISOR/REPRESENTATIVE:

Please mail this form directly to the address on the first page of this form.
If the student intends to hand deliver this form, please sign across the seal of the envelope to ensure authenticity.